

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13817
CERTIFICATE OF DEATH
13792

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rock Run		d. STREET ADDRESS Rock Run	
3. NAME OF DECEASED (Type or print) Andrew Robert Bannon		4. DATE OF DEATH Dec. 12, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		11. BIRTHPLACE (County & State, or foreign country) Cecil Co., Md. U S A	
13. FATHER'S NAME Andrew J. Bannon		14. MOTHER'S MAIDEN NAME Dollie E. Wills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-09-3797	
17. INFORMANT Mabel O. Bannon, Port Deposit, Md. Rural		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO (b) Arterio Sclerosis - Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Chr. Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 6 hours 3 yrs - 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June - 54 Dec. 12, 19 61, that (I) (we) last saw the deceased alive on Dec. 12, 19 61, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE Clarence I. Benson M.D.	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson M.D.		22b. DATE SIGNED Dec. 13, 19 61	
22d. ADDRESS Port Deposit, Md.		22e. REC'D BY REGISTRAR DEC 18 '61	
23a. BURIAL, CREMATION, REBURY (If any) Burial		23b. DATE THEREOF 12-15-1961	
23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		23d. LOCATION (City, town or county) Colora, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE J. A. Patterson		25. REGISTRAR'S SIGNATURE	
ADDRESS Perryville, Md.		DATE	

1261

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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FOR STATE
HEALTH DEPT.
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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton						c. LENGTH OF STAY IN 1b 6 yrs.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.3.						d. STREET ADDRESS											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) UNION HOSPITAL												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Frances Gail Bonham				First Middle Last				4. DATE OF DEATH 12 23 19 61				Month Day Year																	
5. SEX F		6. COLOR OR RACE W		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11-22-1955				9. AGE (In years last birthday) 6 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child						10b. KIND OF BUSINESS OR INDUSTRY Child						11. BIRTHPLACE (State or foreign country) Md.						12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME James R. Bonham						14. MOTHER'S MAIDEN NAME Fanny L. Stroppe																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. _____						17. INFORMANT James R. Bonham, Elkton R.D.3. Md.						Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of both femurs and fracture at base of skull DUE TO 5. min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 812 X DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hit by car as she ran across the road																							
20c. TIME OF INJURY Month, Day, Year 2.45 12 23 61 Hour p.m.						20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work Road						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkton Cecil Md.						20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>																	
ACTUAL SIGNATURE R.C. Dodson M.D.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																	
EXAMINER'S NAME (Type) R.C. Dodson												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF 12-27-61						22c. NAME OF CEMETERY OR CREMATORY N. E. Methodist Cem.						22d. LOCATION (City, town, or country) (State) North East, Md.					
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME												ADDRESS Elkton, Md.						24a. REC'D BY REGISTRAR DEC 27 '61						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. It is to be completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13819

13794

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS 6 Taft	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ALBERT (NMI) BRAUN				4. DATE OF DEATH Month Day Year December 20 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-80	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not available				14. MOTHER'S MAIDEN NAME Not available			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes S.A.W.				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records, VAH, Perry Point, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (XXXXXX Hospital) attended the deceased from 12-17, 1961, to 12-20, 1961, and that death occurred at 8:45pm from the causes and on the date stated above.							
22a. SIGNATURE S. Goldgraben				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-21-61	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN				Chief, Medical Service VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12/22/1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son				ADDRESS Havre de Grace, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
						25b. REGISTRAR'S SIGNATURE Charles E. Thomas	

12701

STATE OF NEW YORK

12701

IN SENATE

January 1, 1911

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN

RESPONSE TO

RESOLUTION

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13820

CERTIFICATE OF DEATH

13796

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
c. LENGTH OF STAY IN lb 16 days			d. STREET ADDRESS 2254 Graythorn Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HOWARD OLIVER BULETTE			4. DATE OF DEATH Month December Day 23 Year 19 61			
5. SEX Male			6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH February 23, 1932			
9. AGE (In years last birthday) 29 yrs.			10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier			10b. KIND OF BUSINESS OR INDUSTRY Postal Service			
11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hugh Bulette			14. MOTHER'S MAIDEN NAME Florence Burkentine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes Korean			16. SOCIAL SECURITY NO. 213-26-1124			
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, severe 592 X DUE TO Chronic Glomulonephritis Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4-6 weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that IV (this hospital) attended the deceased from December 7, 1961 to December 23, 1961 , that IV (we) last saw the deceased alive on Dec. 23rd, 19 61 , and that death occurred at 7:15 PM from the causes and on the date stated above.						
22a. SIGNATURE A. L. Mooney M.D.						22b. DATE SIGNED 12-23-61
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. Asst. Clinical Pathologist, VAH., Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 27, 1961		23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL		
23d. LOCATION (City, town or county) (State) HAVRE DE GRACE MD.		24. FUNERAL DIRECTOR'S SIGNATURE R. MADISON MITCHELL ADDRESS Havre DeGrace, Md.				
25a. REC'D BY REGISTRAR DATE DEC 29 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Frank				

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Key Points

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Harford County, Md.

High Billets

Id. at 230.

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CERTIFICATE OF DEATH

Reg. Dist. No. 18797

13821

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RISING SUN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS PEARL STREET	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLE FREDRICK BURKINS, SR		4. DATE OF DEATH Month Day Year DECEMBER 5, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1903
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACETYLENE BURNER		10b. KIND OF BUSINESS OR INDUSTRY STEEL WORKS	
11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ALFRED BURKINS		14. MOTHER'S MAIDEN NAME LAURA M. SHADE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-01-8683	
17. INFORMANT MRS HAZEL BURKINS, RISING SUN, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/15 , 19 54 , to 12/5 , 19 61 , that I last saw the deceased alive on 12/5 , 19 61 , and that death occurred at 9:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Rising Sun, Md 12/7/61	
PHYSICIAN'S NAME (Type) Neil Taylor Jr. MD		Rising Sun, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/8/1961	22c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM	22d. LOCATION (City, town, or county) (State) COLORA MD.
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun, Md		ADDRESS DEC 8 '61	
24a. REC'D BY REGISTRAR DEC 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13822

CERTIFICATE OF DEATH

Reg. Dist. No. 13798

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home				d. STREET ADDRESS Rd # 4,			
3. NAME OF DECEASED (Type or print) First William Middle Harry Last Carter				4. DATE OF DEATH Month 12 Day 25 Year 19 61			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 29 1880		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81	IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonathan V. Carter				14. MOTHER'S MAIDEN NAME Mary R. Chaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-30-1225		INFORMANT Address ELVA Bostic, RD 3 Coatsville, Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Acute coronary infarction 4201 DUE TO Coronary artery heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) several yrs. DUE TO (c) several yrs.						INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15 , 19 61 to Dec. 25 , 19 61 , that I last saw the deceased alive on Dec. 24 , 19 61 , and that death occurred at 10:15a , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main St., Elkton, Md. DATE SIGNED 12/25/61 ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. 12/25/61 PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/61		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter de Boer Jr ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR JAN 2 '62		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

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VS A1S (4)
15M 9/58

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13823 CERTIFICATE OF DEATH 13799

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN lb 5mo. 19days		d. STREET ADDRESS 631 Maryland Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GLENN HOWARD CORNELL		4. DATE OF DEATH December 3 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-89
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not available		10b. KIND OF BUSINESS OR INDUSTRY Not available	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Cornell		14. MOTHER'S MAIDEN NAME Ellie Spevil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia left lung, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized, - unknown INTERVAL BETWEEN ONSET AND DEATH 10-14 days unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from June 14, 1961 to December 3, 1961 and that death occurred at 3:15 PM from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney M.D.		22b. DATE SIGNED 12-4-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) 12/7/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 8 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Knap	

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THE DEPARTMENT OF HEALTH

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13824

CERTIFICATE OF DEATH

13800

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS 3515 Meadowside Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELLSWORTH G. CROPSY		4. DATE OF DEATH Month Day Year December 19 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-98
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cropsey (deceased)		14. MOTHER'S MAIDEN NAME Lucy Hackley (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXXXXXXXX attended the deceased from December 9 19 61 to December 19 19 61 and that death occurred on 12-20-61 from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 12-20-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12/21/1961	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town or county) Baltimore, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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CENTRAL OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13825

CERTIFICATE OF DEATH

Reg. Dist. No. 13801

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 4½ yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Washington Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Laura Virginia DAVIS				4. DATE OF DEATH Month Day Year Dec. 28, 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Nr. Elkton, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Beers				14. MOTHER'S MAIDEN NAME Sara E. Curry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-05-3877		17. INFORMANT Margaret Bryson, Elkton, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease 10 yrs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 11, 19 59, to Dec. 28, 19 61, that I last saw the deceased alive on Dec. 26, 1961, and that death occurred at 3:45 p.m. from the causes and on the date stated above. Dec. 28, 1961 ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Samuel J. Wright M.D. 79 Amstel Avenue Newark, Del. PHYSICIAN'S NAME (Type) Samuel J. Wright, M.D. Dec. 29, 1961							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-30-61		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem.	
22d. LOCATION (City, town, or county) Cherry Hill, Md. (State)							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. Zee Elkton,				24a. REC'D BY REGISTRAR DATE 2 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

CERTIFICATE OF DEATH

1915

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		1870		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1895		NEW YORK		NEW YORK		NEW YORK		1915		NEW YORK		NEW YORK	
CAUSE OF DEATH		DISEASE		COMPLICATIONS		TREATMENT		PREVIOUS ILLNESS		DATE OF ONSET		PLACE OF ONSET		CITY OF ONSET	
HEART DISEASE		CORONARY ARTERY DISEASE		HYPERTENSION		MEDICINE		NONE		1915		NEW YORK		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		COUNTRY OF BURIAL	
1915		NEW YORK		NEW YORK		NEW YORK		1915		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 1915

1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13802

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY in lb 30 hours		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last An thony R Dvorak Jr.				4. DATE OF DEATH Month Day Year 12 15 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 1-17-60		9. AGE (in years last birthday) 1	IF UNDER 1 YEAR Months Days 28	IF UNDER 24 HRS. Hours Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME An thony Dvorak				14. MOTHER'S MAIDEN NAME Ruth Di Feraei man de			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Anthony Dvorak Nr. Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 560.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Operat ion lef t Inguinal hernia (c) DUE TO cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson		M.D. ASSISTANT MEDICAL EXAMINER Rising Sun		DATE SIGNED 12-15-61			
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER Rising Sun		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/61		22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Nr. Elkton, Maryland		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME				24a. REC'D BY REGISTRAR DEC 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13827

13803

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 28 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 110 Bridge Street	
3. NAME OF DECEASED (Type or print) First ALFRED Middle LEROY Last EDER		4. DATE OF DEATH Month December Day 24 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Custodian		10b. KIND OF BUSINESS OR INDUSTRY General	9. AGE (In years last birthday) 69 yrs.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred W. Eder (Deceased)		14. MOTHER'S MAIDEN NAME Mary Harrington (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 219-03-3611	
17. INFORMANT VA Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF TONGUE WITH METASTASIS TO LIVER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 7-10 Days 7 Months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 11/26/ , 19 61 to 12/24/ , 19 61 , that XXXXXX XXXXXX and that death occurred at 5:40 AM from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 12/24/61	
22c. PHYSICIAN'S NAME (Type) A. L. Mooney, M.D.		22d. ADDRESS VAH, Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-61	
23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cem.		23d. LOCATION (City, town or county) (State) Elkton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Pippins Funeral Home, Elkton, Md.		25a. REC'D BY REGISTRAR DEC 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

13802

13803

Geoff Henryland Geoff

Elkton 28 Days Ferry N. 1st

Veterans Administration Hospital 110 Bridge Street

ALBANY 28 Days 28 Days

Male White 28 Days 28 Days

Red Cross Chaplain 28 Days 28 Days

Frank A. Edor (Deceased) Mary Harrington (Deceased)

Yes No I 219-3-3411 VA Records, VA, Ferry Point, Md.

CHRONOLOGICAL

7-10 Days

7 Months 7 Months

11/25/51 11/25/51 11/25/51

2:40 2:40 2:40

VA, Ferry Point, Maryland 11/25/51

11/25/51 11/25/51 11/25/51

Shipping Funeral Home, Elkton, Md. 11/25/51

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13828

13804

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
c. LENGTH OF STAY IN lb 8 days		d. STREET ADDRESS Rt. 2, Box 24	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADOLPH S. ELASEWITCH		4. DATE OF DEATH December 7 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-96	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days 12 x 2	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adam Elasewitch (deceased)		14. MOTHER'S MAIDEN NAME Margaret Seibert (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 220-03-0299	
17. INFORMANT Not available		Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmia DUE TO (b) Arteriosclerotic heart disease severe with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) myocardial fibrosis and mural thrombosis Arteriosclerosis generalized		INTERVAL BETWEEN ONSET AND DEATH 1-3 minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xx (XXXXXX) xx attended the deceased from November 29, 1961, to December 7, 1961, and that death occurred at 8:30am M. from the causes and on the date stated above.			
22a. SIGNATURE A. L. MOONEY		22b. DATE SIGNED 12-7-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Dec. 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Lindsey & Sons, F.H.,		23d. LOCATION (City, town or county) (State) Harrisonburg Va.,	
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS Abingdon, Md.,		DATE DEC 11 '61	

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STATE OF TEXAS

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13829

CERTIFICATE OF DEATH

13805

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown	
c. LENGTH OF STAY IN 1b 18 MONTHS		d. STREET ADDRESS Queen St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Devine Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Fowler		4. DATE OF DEATH Month Day Year 12/2/61 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1874
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer at Lumber yard		11. BIRTHPLACE (County & State, or foreign country) Kent Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Fowler	
14. MOTHER'S MAIDEN NAME Emma Ford DeFord		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. (If as giver or detest of service) 213-05-5017		17. INFORMANT Address Clarence Fowler - Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 mos. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to 2 Dec 1961, that (I) (we) last saw the deceased alive on 2 Dec 1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Wallace Obenshain		22b. DATE SIGNED 2 Dec 61	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain		22d. ADDRESS Cecil, Hon, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF L2/5/61	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		25a. REC'D BY REGISTRAR DEC 5 '61	
25b. REGISTRAR'S SIGNATURE Anthony L. Thomas			

M

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13222

William O. Ochs

Charles Ochs

Charles Ochs

13222

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13830

13806

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville c. LENGTH OF STAY IN lb 30 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Front St.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville d. STREET ADDRESS Front St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Claude S. Hackler				4. DATE OF DEATH Month Dec. Day 15 Year 61								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1909		9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Dispatcher. U S V Hospital.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Bruce Hackler				14. MOTHER'S MAIDEN NAME Cynthia Hash								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) World W. 2				16. SOCIAL SECURITY NO. 721-18-0031				17. INFORMANT Ruth Stowell, North East, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage (intracranial) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral embolism (c) Coronary thrombosis (Myocarditis) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):										INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 minutes 1 hour -		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (his hospital) attended the deceased from June 1945 to December 1961, that (I) (we) last saw the deceased alive on December 14, 1961, and the death occurred at 3A M, from the causes and on the date stated above.												
22a. SIGNATURE Frank Wolbert MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED December 18, 1961				
22c. PHYSICIAN'S NAME (Type) FRANK WOLBERT MD						22d. ADDRESS HAVER DE GRACE MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery				23d. LOCATION (City, town or county) Port Deposit, Md. Rural		
24. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son						ADDRESS Perryville, Md		25a. REC'D BY REGISTRAR DEC 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(K)

13220

Coast

Portville

Hydro. C.

Urbans

Rockier

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Aug. 1902

23

Hospital.

Yes.

Cynthia

Leah

Spence

Yes

181-12-01

Southwestern

13831

CERTIFICATE OF DEATH

Reg. Dist. No. 13807

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Viola Middle H Last Harrington		4. DATE OF DEATH Dec. 20 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Rising Sun, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert C. Harrington		14. MOTHER'S MAIDEN NAME Sarah Hoopes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. William Lupfer, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chronic hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1961, to Dec 20, 1961, that I last saw the deceased alive on Dec 20, 1961, and that death occurred at 5:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12/20/61			
ACTUAL SIGNATURE HENRY U. DAVIS M.D. CHESAPEAKE CITY, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-61	
22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or county) (State) Rising Sun R.D. Cecil, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE DEC 27 '61	

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VS A15 (4)
15M 9/58

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13832

13808

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Md. c. LENGTH OF STAY IN lb 57 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Pa. f. COUNTY York g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fawn Grove h. STREET ADDRESS General Delivery i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Avon W. Hess		4. DATE OF DEATH Month Day Year 12-21 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-4-93	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 11 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Stewartstown, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Lincoln Hess		14. MOTHER'S MAIDEN NAME ANNIE Shue (First name not available)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 159-03-5812	
17. INFORMANT VA Hospital Records - VA Hospital Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased attended the deceased from Oct 25 , 19 61 to Dec 21 , 19 61 , and that death occurred on Dec 21 , 19 61 , at 6:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 12-21-61	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, Chief, Medical Service		22d. ADDRESS VA Hospital - Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12 23 61	
23c. NAME OF CEMETERY OR CREMATORY First Methodist Church Cemetery - Fawn Grove, Pa.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE R. W. Osburn		25a. REC'D BY REGISTRAR DEC 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Trane		25c. ADDRESS OSBURN FUNERAL HOME - Stewartstown, Pa.	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13833

CERTIFICATE OF DEATH

Item 8 Film G303 12/27/61 mb

13809

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS Rd # 4,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frances A. Jackson		4. DATE OF DEATH Month Day Year 12 13 1961	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/1964 1888
9. AGE (In years last birthday) yrs. Months Days 73		10. IF UNDER 1 YEAR Hours Min. 12 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY House Work	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Aument		14. MOTHER'S MAIDEN NAME Ella Forbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 213-0-10017	
17. INFORMANT Walter Jackson		Address Elk Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) Carcinoma of the colon		INTERVAL BETWEEN ONSET AND DEATH unknown over 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Aug. 29 61 Dec. 13 61	
21. I certify that (I) (this hospital) attended the deceased from Dec. 13 61 to 6:06p , 19 61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE S. Ralph Andrews, Jr.		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 233 E. Main St., Elkton, Maryland	
22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 12/16/61	
23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		23d. LOCATION (City, town or county) (State) Cherry Hill Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Walter de Bone, Jr.		ADDRESS Elkton, Md.	
25a. REC'D BY REGISTRAR DEC 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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W. H. Anderson

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13834

13810

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b 6 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peral Street				d. STREET ADDRESS Peral Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Marie Kennard				4. DATE OF DEATH Month 12/ Day 20 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18, 1880	
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allison Henry				14. MOTHER'S MAIDEN NAME Mary Burkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Joseph Pogue Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 45010 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 wks 3 y5							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 9 1960 to 12/20 61 , that (I) (we) last saw the deceased alive on 12/19 61 , and that death occurred at P M, from the causes and on the date stated above.							
22a. SIGNATURE Neil R. Taylor Jr.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Neil R. Taylor Jr.	
22d. ADDRESS Rising Sun, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/1961		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem		23d. LOCATION (City, town, or county) (State) Colora Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lemon E. McMiller				25a. REC'D BY REGISTRAR DATE DEC 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	
25c. ADDRESS Rising Sun, Md.							

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Walt B. Taylor

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CERTIFICATE OF DEATH

Reg. Dist. No. 13811

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>36 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>				d. STREET ADDRESS <u>1 BOHEMIA AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary ELIZABETH Lee</u>				4. DATE OF DEATH Month Day Year <u>Dec 10 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 17, 1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Elkton md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Anna Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>FRANK LEE</u>		Address <u>CHESAPEAKE CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebellar Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis, Coronary Artery Sclerosis, Huge ovarian Cyst.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10 Dec</u> , 19 <u>61</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Wallace Obenshain</u> M.D. <u>11 Dec 61</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Wallace Obenshain</u> <u>Cecilton, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 14, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ELKTON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF BIRTH

13753

STATE OF ARIZONA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF BIRTHS

Name of Child	
Sex	
Date of Birth	
Place of Birth	
Time of Birth	
Weight	
Length	
Head	
Chest	
Abdomen	
Feet	
Fingers	
Eyes	
Ears	
Nose	
Mouth	
Throat	
Lungs	
Heart	
Liver	
Spleen	
Pancreas	
Intestines	
Stomach	
Bladder	
Uterus	
Vagina	
Cervix	
Perineum	
Anus	
Rectum	
Colon	
Small Intestine	
Duodenum	
Jejunum	
Ileum	
Cecum	
Appendix	
Sigmoid	
Rectum	
Anus	
Perineum	
Cervix	
Vagina	
Uterus	
Bladder	
Stomach	
Intestines	
Pancreas	
Spleen	
Liver	
Heart	
Lungs	
Throat	
Mouth	
Nose	
Ears	
Eyes	
Fingers	
Feet	
Abdomen	
Chest	
Head	
Length	
Weight	
Time of Birth	
Place of Birth	
Date of Birth	
Sex	
Name of Child	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13836

13812

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 8yrs.9mo.8days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY Philadelphia		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 75X-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 4247 Penn Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) WILLIAM J. LEIPERT		4. DATE OF DEATH December 14 19 61												
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-88		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME Joseph Leipert		14. MOTHER'S MAIDEN NAME Not available												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I 168-16-6890		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericarditis 4 4 2 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Arterioneuroclerosis										INTERVAL BETWEEN ONSET AND DEATH 15-20 days 15-20 days unknown				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that XXXXXX attended the deceased from March 6, 1953, to December 14, 1961, and that death occurred at 4:55 AM from the causes and on the date stated above.														
22a. SIGNATURE A. L. Mooney		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-14-61				
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY		Asst. Clinical Pathologist, VAH, Perry Point, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) 12/18/61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Beverly National		23d. LOCATION (City, town or county) Beverly, New Jersey		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus								

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CHARTER OF RIGHTS

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1 2
FOR STATE
HEALTH DEPT.

any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13837 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13813

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
c. LENGTH OF STAY IN 1b 20 yrs.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) First Middle Last Charles WESTON Loveless		4. DATE OF DEATH Month Day Year Dec. 20, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boats		10b. KIND OF BUSINESS OR INDUSTRY General Laborer	9. AGE (In years last birthday) 78
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Loveless		14. MOTHER'S MAIDEN NAME Rachel Horner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 339-16-0574	
17. INFORMANT Rachel Loveless, Chesapeake City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cronia Myocarditis Hypertension 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 3 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. DODSON		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 12-20-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/23/61	22c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY	22d. LOCATION (City, town, or country) (State) NR. CHESAPEAKE CITY, Md.
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
ADDRESS 1401 1/2 DEAN ELKTON, Md.		DATE DEC 22 '61	

DATE OF
DEATH

DATE

TIME

PLACE

CAUSE

MODE OF DEATH

DEATH

DEATH

Signature

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b all life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Providence, Elkton, R.D.5. d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Pierce Taylor Malin				4. DATE OF DEATH Month Day Year 12 19 61			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-23-1913	
9. AGE (In years last birthday) 48 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Bennett Loken Malin Malon				14. MOTHER'S MAIDEN NAME Elizabeth Catherine Anderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 222-07-0963			
17. INFORMANT Mrs. Peire Taylor Malin				Address Elkton, R.D.5. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 12-50 12/19/61				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Attached hose of tail pipe and inside of cab of truck			
20e. CITY OR TOWN Elkton R.D.5 Cecil Md.				20f. COUNTY Cecil			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R.C. Dodson</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-20-61				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/23/61			
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cem.				22d. LOCATION (City, town, or country) (State) Cecil County, Md.			
23. FUNERAL DIRECTOR Ralph E. Hicks, Elkton, Md.				24a. REC'D BY REGISTRAR JAN 11 '62			
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hawks</i>							



Coall

Elkton

all life

Providence, Elkton, R.D. 5.

Coall

Ma.

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Walter

Taylor

Pharo

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18

2-23-1913

W

X

U.S.A.

Ma.

Bank dealer

Resident in Anderson

Bennett taken taken taken

Mrs. Patsy Taylor Nelson, Elkton, R.D. 5, Ma.

Carbon monoxide poisoning

x

x

Attached home of tail pipe and inside of cap of tank

Ma.

Elkton R.D. 5 Coall

Bank yard

x

12-20-13

12-20

x

x

x

12-20-13

x

Missy S.M. Ma.

R.D. Hobson

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13814

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Elkton	
c. LENGTH OF STAY IN 1b 1 year		d. STREET ADDRESS Browns Shore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Browns Shore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurice Henry Matsinger, Jr.		4. DATE OF DEATH Dec. 19, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1914
9. AGE (In years last birthday) 47 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Maintenance	
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris H. Matsinger, Sr.		14. MOTHER'S MAIDEN NAME Irene Kennedy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 173-10-4560	
17. INFORMANT Lucille Matsinger, R. D. #1, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 22 Bullet in the forehead DUE TO 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot self with 22 caliber rifle	
20c. TIME OF INJURY Month, Day, Year 3:05 P.M. 12/19/61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence		20f. (City or town) R.D. #1, Elkton, Cecil, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. DODSON, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. DODSON, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-61	
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk. Nr. Elkton, Md.		22d. LOCATION (City, town, or country) (State) Md.	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

12333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13840
CERTIFICATE OF DEATH
13815

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Springfield	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 5303 Clifton Street	
3. NAME OF DECEASED (Type or print) JOSEPH (N)one MOFFATT		4. DATE OF DEATH Month 12 Day 18 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-93
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 83 Days x-3	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) New Castle, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH MOFFATT		14. MOTHER'S MAIDEN NAME SARAH NIMMO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 577-24-6257	
17. INFORMANT Mrs. Ada E. Moffatt (Wife)		Address 5303 Clifton St., Springfield, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia, left lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Old Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 7 To 10 Dys. Approx. 6 Mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 6-15- to 12-18- and that death occurred at 2:PM , from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 12-18-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12/19/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13841				CERTIFICATE OF DEATH				13816			
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural				c. LENGTH OF STAY IN 1b 3 Yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City, Rural					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel D. Moore						4. DATE OF DEATH Dec. 18 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5, 1885		9. AGE (in years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (County & State, or foreign country) Cecil Co., Md.				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Moore				14. MOTHER'S MAIDEN NAME Sarah Ann Parks							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 169-20-1560		17. INFORMANT Mrs Cyrus Burlin, Port Deposit, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (c) DISSEMINATED SCLEROSIS cause last. INFECTIOUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 2 mos. 10 yrs. 166.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 1961, to Dec 18, 1961, that (I) (we) last saw the deceased alive on 12-18-1961, and that death occurred at 8 P.M. from the causes and on the date stated above.											
22a. SIGNATURE G.H. Richards Jr. M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-19-61			
22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr.						22d. ADDRESS Port Deposit, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-1961		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Md. Rural					
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR DEC 22 61		25b. REGISTRAR'S SIGNATURE Cecil A. Hanks			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13842

CERTIFICATE OF DEATH

13817

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN b 109 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VAH, Perry Point, Maryland		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS Post Office Box 245 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY C. PEITZ		4. DATE OF DEATH December 19, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/90
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Navy	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Peitz	
14. MOTHER'S MAIDEN NAME Katie Hess		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service) Yes WWI & II	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT VA Records, VAH, Perry Point, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL 350.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DEBILITATION, CHRONIC DUE TO (c) PARKINSON'S DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 7-10 Days Months Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that A. L. MOONEY attended the deceased from Sept. 1, 1961 , to Dec. 19, 1961 , and that death occurred at 6:10 PM from the causes and on the date stated above.			
22a. SIGNATURE A. L. MOONEY		22b. DATE SIGNED 12/20/61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VAH, Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/1961	
23c. NAME OF CEMETERY OR PLACE OF BURIAL Arlington Nat'l. Cem.		23d. LOCATION (City, town or county) (State) Ft. Myer, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13242

Occell

100 Days

Upper Harbor

VN, Ferry Point, Maryland

Post Office Box 243

HENRY

FRITZ

C.

Male 10/10/50 6/12/50

Ret. Navy

Washington, D. C.

John Foster

Walt, Bob

Yes MI & II

Yes

VN, Ferry Point, Maryland

BROWNSVILLE, TEXAS

7-10 Days

DEMILITATION, CHICAGO

10/10/50

WASHINGTON, D.C.

10/10/50

I

Sept. 1 61 Dec. 19 61

A. J. HOSKIN, U.S. Army, Ferry Point, Maryland

Washington, D.C., Ret. Navy, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 (M)
Known locally as Bessie Garrison (Price)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13843						13818					
1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Cecil</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>EMMA E. PRICE</i> First Middle Last 4. DATE OF DEATH <i>Dec. 17, 1961</i> Month Day Year						5. SEX <i>Female</i> 6. COLOR OR RACE <i>Caucasian</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Feb. 14, 1883</i> 9. AGE (In years last birthday) <i>78</i> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Cecilton md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						13. FATHER'S NAME <i>James Thompson</i> 14. MOTHER'S MAIDEN NAME <i>Julia Thompson</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <i>Emma Harrison Cecilton 3, Md.</i> Address <i>334 1/2 3rd ally</i>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial infarction, massive</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Severe coronary sclerosis, severe congestive heart failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 hours.</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>June 8 1961 to 17 Dec 61</i> <i>4:20 AM</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that (I) (this hospital) attended the deceased from <i>June 8 1961</i> to <i>17 Dec 61</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>17 Dec 61</i> , 19 <i>61</i> , and that death occurred at <i>4:20 AM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Wallace Obenshain</i> M.D. 22c. PHYSICIAN'S NAME (Type) <i>Wallace Obenshain, M.D.</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Cecilton, Md.</i> 22b. DATE SIGNED <i>19 Dec 61</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Dec. 21, 1961</i> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY <i>Cecilton Cemetery</i> 23d. LOCATION (City, town or county) (State) <i>Cecilton md.</i>						24. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Bellows</i> ADDRESS <i>Cecilton md.</i> 25a. REC'D BY REGISTRAR <i>DEC 26 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Carlton L. Hume</i>					

13818

13818

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JAN 10 1900
U. S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13844

13819

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> c. LENGTH OF STAY IN 1b <u>42 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>-</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CURTIS W. REED</u>				4. DATE OF DEATH Month Day Year <u>12 25 19 61</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-19-1874</u>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>12</u> Days <u>25</u> Hours <u>19</u> Min. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Bridge Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>No information</u>				14. MOTHER'S MAIDEN NAME <u>No information</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Albert Reed North East, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> 4-50.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>-</u> (c) <u>-</u> DUE TO (e), stating the underlying cause last. <u>-</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hypertrophic osteoarthritis; diabetes mellitus; prostatic hypertrophy</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) <u>-</u>		(County) <u>-</u>		(State) <u>-</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan 1961</u> to <u>25 Dec 1961</u> , that (I) (we) last saw the deceased alive on <u>24 Dec 1961</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Klaus H. Huebner</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/25/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>				22d. ADDRESS <u>North East, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-28-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		23d. LOCATION (City, town or county) (State) <u>North East, Cecil Co., Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> <u>Joseph R. Grant North East, Md</u>				ADDRESS <u>-</u>		25a. REC'D BY REGISTRAR <u>DEC 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13845
CERTIFICATE OF DEATH
13820

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. LENGTH OF STAY IN lb 1 yr. 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last RENNER		4. DATE OF DEATH Month 12- Day 19 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 2-20-93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman		10b. KIND OF BUSINESS OR INDUSTRY Not available	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES RENNER		14. MOTHER'S MAIDEN NAME GEORGIANA ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 213-16-5877	
17. INFORMANT Hospital Records & Mother, Mrs. Georgian Renner, 3600 Fairview Ave., Balto., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Bronchopneumonia, Bilateral DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Emphysema With Bronchiectasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 5 27 1		INTERVAL BETWEEN ONSET AND DEATH 7 Days 1 Year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that JOHN H. RENNER attended the deceased from 11-27- 1960, to 12-19- 1961, that he was the cause of death and that death occurred at 2:55 PM from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney M.D.		22b. DATE SIGNED 12-20-61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY Asst. Clinical		22d. ADDRESS VA HOSPITAL, PERRY POINT, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12/22/1961	
23c. NAME OF CEMETERY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns			

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Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: a control group and an experimental group. The control group received a standard treatment, while the experimental group received a treatment with a specific intervention. The results were then compared between the two groups.

— 55 —

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY —					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
c. LENGTH OF STAY IN 1b 15 days					d. STREET ADDRESS 3806 Forrester Avenue					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE BRITTON ROBBINS					4. DATE OF DEATH Month Day Year December 14 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-18-89		9. AGE (In years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Television		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME George B. Robbins (deceased)					14. MOTHER'S MAIDEN NAME Elizabeth Thomas (deceased)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-I					16. SOCIAL SECURITY NO. 161-18-0680					
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Lung Abscess, Bronchopneumonia, Bilateral & RLL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma, Left Lung DUE TO (c) Unknown					INTERVAL BETWEEN ONSET AND DEATH 2 To 3 Wks.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (Name of deceased) attended the deceased from November 29 19 61 to December 14 19 61, and that death occurred at 3:40 AM from the causes and on the date stated above.										
22a. SIGNATURE A. L. MOONEY M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-14-61			
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12/17/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son Have de Groot Inc					ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 20 '61		25b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13847

CERTIFICATE OF DEATH

Reg. Dist. No. 13822

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital H				d. STREET ADDRESS Rd # 4,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Emiline Last Ruth				4. DATE OF DEATH Month 12 Day 25 Year 1961			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/1881	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Temple				14. MOTHER'S MAIDEN NAME Hoopes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) * - - - - -				16. SOCIAL SECURITY NO. 213-14-4034 INFORMANT Roy A. Temple Address Elk Mills Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4-22-1 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH several yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitis and fracture of left humerus on 12/16/61							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 14 , 19 61 to Dec. 25 , 19 61 , that I last saw the deceased alive on Dec. 25 , 19 61 , and that death occurred at 5:40p M, from the causes and on the date stated above.				DATE SIGNED 12/26/61			
ACTUAL SIGNATURE [Signature]		M.D. S. Ralph Andrews, Jr., M.D.		ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/61		22c. NAME OF CEMETERY OR CREMATORY Lawn Craft Cemetery		22d. LOCATION (City, town, or county) (State) Linwood Pa.	
23. FUNERAL/DIRECTOR'S SIGNATURE H. Walter du B...				24a. REC'D BY REGISTRAR DATE JAN 2 '62		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

1889



DECEASED

Blank lines for recording death information.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13848					13823									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		Cecil			e. STATE		Md.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Elkton			b. COUNTY		Cecil							
c. LENGTH OF STAY IN 1b		2 Min.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Elkton							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Union Hosp.														
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX								
First Middle Last			Month Day Year											
Shirley R. Streets			December 6, 1961											
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR						
White				Dec. 6, 1961				Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
None		None		Maryland		USA								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Herman W. Streets					Frances M. Clarke									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No					None					Herman W. Streets Nr. Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 750X DUE TO An encephaly										7 months				
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
June 1961					June 1961		Dec 6 1961							
21. I certify that (I) (this hospital) attended the deceased from June 1961 to Dec 6 1961, that (I) (we) last saw the deceased alive on Dec 6 1961, and that death occurred at 10 PM, from the causes and on the date stated above.														
22a. SIGNATURE					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)							
Joseph G. Lanzi					12/8/61		Joseph G. Lanzi							
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial					12/9/61		Elkton Cemetery		Elkton, Maryland					
24 FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
PIPPIN FUNERAL HOME					Dond/m Dec Elkton, Md.		DEC 14 61							

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MEDICAL CERTIFICATION

INDEX

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John A. Smith

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• In 1997, a 100% increase in ISL

Is there information available?

151 Bonnie View Road

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Y. ZHANG

Accepted: 5/1/98

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2. *Carolina*

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26



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THINGS TO REMEMBER

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Medical Records, VA Hospital, Perry Point, Md.

Online-Veröffentlichung w/0 datenschutzrechtliche Hinweise.

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Figure 5. Effect of the concentration of the initiator on the polymerization of α -methylstyrene in the presence of SnCl_4 at 0°C .

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Безопасность, контроль

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>11</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Cecil</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		d. STREET ADDRESS <u>1601 G. H. Palmer St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Troutner</u> Last <u>Troutner</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>Sept</u> Day <u>25</u> Year <u>1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>					
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Commercial Fishing</u>		13. BIRTHPLACE (County & State, or foreign country) <u>no record</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no record</u>		16. SOCIAL SECURITY NO. <u>219-16-3985</u>		17. INFORMANT <u>Welfare Records Cecil Co.</u>		18. ADDRESS <u>Maryland</u>					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Palmonary Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Senility</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u>Senility</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-Vascular Accident - 4 days</u>		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. INTERVAL BETWEEN ONSET AND DEATH <u>7 min</u> <u>years</u>		23. MEDICAL CERTIFICATION		24. MEDICAL CERTIFICATION		25. MEDICAL CERTIFICATION		26. MEDICAL CERTIFICATION					
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		29. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		30. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		31. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		32. (City or town) (County) (State)		33. I certify that (I) (this hospital) attended the deceased from <u>1 Dec</u> 19 <u>61</u> , to <u>5 Dec</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5 Dec</u> 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.		34. SIGNATURE <u>Wallace O'Brien</u> M.D.		35. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		36. DATE SIGNED <u>6 Dec 61</u>	
37. PHYSICIAN'S NAME (Type) <u>Wallace O'Brien</u>		38. ADDRESS <u>Cecil Co. Md</u>		39. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		40. DATE THEREOF <u>12-7-1961</u>		41. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		42. LOCATION (City, town or county) (State) <u>North East Cecil Co Md</u>		43. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant</u>		44. ADDRESS <u>North East Md</u>		45. REC'D BY REGISTRAR <u>DEC 8 '61</u>		46. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	

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13820

13820

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "January" and "February" are faintly visible.]

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13851

14657

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE PA b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - OXFORD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS RD 3	
3. NAME OF DECEASED (Type or print) SANDRA GEAN Weaver		4. DATE OF DEATH Dec 12 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Robert T Weaver		14. MOTHER'S MAIDEN NAME JOAN HALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert Weaver		Address RD 3, OXFORD, PA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 754.2 DUE TO (1) Congestive heart failure, right heart failure with hypertrophy of right ventricle and dilation of right ventricle (2) Right heart failure (3) Double ventricular septal defect Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (1) Right heart failure (2) Double ventricular septal defect PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-12, 1961, to 12-12, 1961/that (I) (we) last saw the deceased alive on 12-12, 1961 and that death occurred at 7:00 PM from the causes and on the date stated above.			
22a. SIGNATURE T. Johnson M.D.		22b. DATE SIGNED 12-14-61	
22c. PHYSICIAN'S NAME (Type) T. Johnson		22d. ADDRESS 123 Singler Ave Elkton	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 14/61	
23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION (City, town or county) (State) Oxford, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		25a. REC'D BY REGISTRAR DATE JAN 11 '62	
ADDRESS Elkton, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13852

CERTIFICATE OF DEATH

13826

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 No 2 - Walter Boulevard St ELKTON</u> d. STREET ADDRESS <u>Sugarloaf Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>C.</u> Last <u>Wisser</u> DATE OF DEATH <u>DEC. 13, 1961</u>		9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6 - 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freeman Brick Works</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refectory Brick Works</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lawrenceburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Wisser</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Meyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CAGREES SMITH</u>		Address <u>PITTSBURG, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>260 X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>bleebetes + myocarditis</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>bleebetes about 3 years - myocarditis - malefined.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 11, 1961</u> , to <u>Dec 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 13, 1961</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>H. Arthur Cantwell M.D.</u>		22b. DATE SIGNED <u>Dec 16</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. Arthur Cantwell M.D.</u>		22d. ADDRESS <u>North East, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/14/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PITTSBURG</u>		23d. LOCATION (City, town or county) (State) <u>PENNA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ELKTON</u>	
ADDRESS <u>MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>DEC 18 '61</u>			

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Malin			First Middle Last A. Worth			4. DATE OF DEATH 12 9 1961			Month Day Year		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-1925		9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Laundry and Dry Cleaning Estab.		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME I. Malin Worth						14. MOTHER'S MAIDEN NAME Rachel E. Worth					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 11		17. INFORMANT I. Malin Worth		Address Elkton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Rupture 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Infart (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH instant 1 yr.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R.C. Dodson						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12-10-1961		
EXAMINER'S NAME (Type) R.C. Dodson						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county) Rising Sun, Md											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-12-1961		22c. NAME OF CEMETERY OR CREMATORY Methodist				22d. LOCATION (City, town, or country) (State) North East Cecil, Md	
23. FUNERAL DIRECTOR Joseph R. Grant North East, Mr.						24a. REC'D BY REGISTRAR DEC 14 '61		24b. REGISTRAR'S SIGNATURE			

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[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13854 Item 6 Film G304 1/3/62 iwk 13828

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELKTON				c. LENGTH OF STAY IN b. 9 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) UNION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY S. WYRE				4. DATE OF DEATH Month Day Year 12 26 1961			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-27-1943	
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME MILFORD WYRE				14. MOTHER'S MAIDEN NAME Ada Rocky			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs Ada Wyre 164 E. Main St. Elkton Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right 286.5 DUE TO Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) all of life (c) all of life				INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked physical and mental retardation				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Dec. 17 61 Dec. 26 61	
21. I certify that (I) (this hospital) attended the deceased from Dec. 25 61 to 7:20a , that (I) (we) last saw the deceased alive on Dec. 25 61 , and that death occurred at 7:20a , from the causes and on the date stated above.							
22a. SIGNATURE Ralph Andrews Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/26/61	
22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				22d. ADDRESS 233 E. Main St., Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-61		23c. NAME OF CEMETERY OR CREMATORY Methodist		23d. LOCATION (City, town or county) (State) North East Cecil Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant North East Md				25a. REC'D BY REGISTRAR DEC 29 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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